STATE OF CALIFORNIA ARNOLD SCHWARZENEGGER, *Governor*

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February 24, 2004

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Department of Justice
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Sacramento, CA 94244-4973

RE: **Order to Set Aside Statement of Decision of January 26, 2001 and Proposed Statement of Decision**

Medically Indigent Adults, CSM R-S046843 (ON REMAND FROM THE CALIFORNIA SUPREME COURT: *County of San Diego v. State of California, et. al.* (1997) 15 Cal. 4th 68).

Dear Mr. Barry and Mr. de la Guardia:

In accordance with the Superior Court of San Diego's judgment and peremptory writ of mandamus in *County of San Diego v. State of California* (GIC762953), the Commission's Proposed Order to Set Aside Statement of Decision of January 26, 2001 and Proposed Statement of Decision is complete and enclosed for your review.

Commission Hearing

This item is set for hearing on Thursday, **March 25, 2004** at 9:30 a.m. in Room 126 of the State Capitol, Sacramento, California. This item will be scheduled for the consent calendar unless any party objects. Please let us know in advance if you or a representative will testify at the hearing, and if other witnesses will also appear.

Special Accommodations

For any special accommodations such as a sign language interpreter, an assistive listening device, materials in an alternative format, or any other accommodations, please contact the Commission Office at least five to seven *working* days prior to the meeting.

Please contact Eric Feller at (916) 323-8221 if you have any questions regarding the above.

Sincerely,

PAULA HIGASHI
Executive Director

Enclosure.

cc. Jaime Rene Roman, Administrative Law Judge, Office of Administrative Hearings.
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ITEM 13

ORDER TO SET ASIDE COMMISSION DECISION OF JANUARY 26, 2001 AND

PROPOSED STATEMENT OF DECISION

No. CSM R-S046843 (On Remand from the California Supreme Court, *County of San Diego v. State of California* (1997) 15 Cal.4th 68) and

County of San Diego v. Commission on State Mandates, et al. (September 24, 2003, D039471) [nonpub. opn.]. (On Remand from the California Court of Appeal, Fourth Appellate District, Division One)

Medically Indigent Adults

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Medically Indigent Adults

EXECUTIVE SUMMARY

In *County of San Diego* v. *State of California* (1997) 15 Cal.4th 68, the California Supreme Court held that the Legislature's exclusion of medically indigent adults from the California Medical Assistance Program (Medi-Cal) mandated a new program or higher level of service on San Diego County ("County") within the meaning of article XIII B, section 6 of the California Constitution. The Supreme Court remanded the matter to the Commission on State Mandates ("Commission") to "determine whether, and by what amount, the statutory standards of care...forced San Diego to incur costs in excess of the funds provided by the state, and to determine the statutory remedies to which San Diego is entitled."

On January 26, 2001, the Commission issued, with minor modifications, a Statement of Decision of an administrative law judge dismissing the County's claim.

The County challenged the January 2001 decision, and the case reached the Court of Appeal. The court disagreed with the Commission's decision, and issued an opinion finding that the County had incurred state mandated costs in the amount of $3,455,754.

On January 28, 2004, the San Diego County Superior Court entered judgment and issued a peremptory writ of mandate directing the Commission to set aside the Statement of Decision of January 26, 2001, and issue a new decision consistent with the court's ruling.

Attached is the proposed order to set aside the Commission's prior decision, along with a copy of that Statement of Decision (Exhibit A), a Proposed Statement of Decision that incorporates the unpublished Court of Appeal decision (Exhibit B), and the San Diego Superior Court's Writ of Mandamus and Judgment Granting Peremptory Writ (Exhibit C).

Staff Recommendation

Staff recommends that the Commission adopt the order to set aside the January 26, 2001 decision (Exhibit A), and adopt the Proposed Statement of Decision (Exhibit B).

BEFORE THE
COMMISSION ON STATE MANDATES
STATE OF CALIFORNIA

ON REMAND FROM THE CALIFORNIA SUPREME COURT: *County of San Diego* Petitioner, *v.* *State of California, et. al.* Respondent (1997) 15 Cal. 4th 68.	No. CSM R-2046843 *Medically Indigent Adults* ORDER TO SET ASIDE STATEMENT OF DECISION OF JANUARY 26, 2001 (Proposed for adoption March 25, 2004)

ORDER TO SET ASIDE STATEMENT OF DECISION

On January 28, 2004, the San Diego County Superior Court entered judgment and issued a peremptory writ of mandate, pursuant to the opinion of the California Court of Appeal, *County of San Diego v. Commission on State Mandates, et al.* (September 24, 2003, D039471) [nonpub. opn.], directing the Commission on State Mandates (Commission) to set aside the Statement of Decision of January 26, 2001, and issue a decision that the applicable standards of care forced the County of San Diego to incur $3,455,754 in costs in excess of the funds provided by the State of California, and therefore the State is required to reimburse the County of San Diego in this amount.

In accordance with the peremptory write of mandate, the Commission hereby sets aside the Statement of Decision of January 26, 2001, a copy of which is attached hereto.

BEFORE THE
COMMISSION ON STATE MANDATES
STATE OF CALIFORNIA

ON REMAND FROM THE CALIFORNIA SUPREME COURT: *County of San Diego* Petitioner, *v.* *State of California, et al.* Respondent. (1997) 15 Cal. 4th 68.	No. CSM R-2046843 *Medically Indigent Adults* STATEMENT OF DECISION PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; TITLE 2, CALIFORNIA CODE OF REGULATIONS, DIVISION 2, CHAPTER 2.5, ARTICLE 7 (Adopted on January 25, 2001)

STATEMENT OF DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Commission on State Mandates as its Statement of Decision in the above-entitled matter, with the following two modifications:

- Page 16. "The net effect of the allowable credits and disallowable expenses thusfar imposed reduce the County's established CMS Program expenses by ~~$6,274,343~~ $4,490,445."
- Page 17, footnote 53. "With the combination of credits and disallowable expenses, this effectively reduces the County's claim for reimbursement to ~~$8,765,651~~ $9,891,895."

This Decision shall become effective on January 26, 2001.

Paula Higashi, Executive Director

BEFORE THE
COMMISSION ON STATE MANDATES
STATE OF CALIFORNIA

COUNTY OF SAN DIEGO, Petitioner, vs. STATE OF CALIFORNIA, Respondent.	CASE No. CSM-R-2046843 OAH No. N2000020064 PROPOSED DECISION FOLLOWING REMAND

PROPOSED DECISION

This matter came on regularly for hearing before Jaime René Román, Administrative Law Judge, Office of Administrative Hearings, in San Diego, California, on May 18 – 19, 2000.

Petitioner County of San Diego ("County") was represented by Timothy M. Barry, Deputy County Counsel, County of San Diego, State of California.

Respondent State of California ("State") was represented by Ramon de la Guardia, Deputy Attorney General, State of California.

Evidence was received and, to allow the submission of written closing arguments, the matter deemed submitted on August 25, 2000.

On September 8, 2000, the Administrative Law Judge ("ALJ") issued a Proposed Decision that was transmitted with exhibits to the Commission on State Mandates ("Commission").

On November 30, 2000, the Commission, following written submissions and oral argument of the parties, ordered the remand[1] of the Proposed Decision to the ALJ "for reconsideration in light of the comments filed by the parties."[2]

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[1] Commission staff, reviewing the submitted Proposed Decision and following the parties' written submissions, recommended remand to the Commission because: "Both parties contend that the amount of credit applied by the hearing officer [ALJ] in the form of a surplus of Short-Doyle funds to reduce San Diego's claim for reimbursement is wrong."

[2] Although Commission staff correctly observed, following the parties' written submissions, discrepancies in the sums credited by the ALJ in the Proposed Decision, the remand recommendation encompassed reconsideration of the parties' comments which was not limited solely to arithmetic sums.

ISSUES PRESENTED ON REMAND[3]

1. Whether the comments filed by the parties, on reconsideration by the ALJ, compels modification of the Proposed Decision.

2. Whether the Proposed Decision erroneously concludes that the County is not entitled to any recovery.

3. Whether the Proposed Decision erroneously credits the State with offsets to which the State is not entitled.

PROCEDURAL FINDINGS

1. The County submits that the Supreme Court[4] "[h]aving found that the State had illegally transferred fiscal responsibility for MIA's to the counties in violation of the California Constitution; having found that the State's failure to fully fund its MISP triggered the County's obligation to provide medical services as the provider of last resort under [Welfare & Institutions Code] section 17000; and having found that the County did not have discretion to refuse to provide medical care to MIA's, the Court held that on remand the State could argue that particular services exceeded statutory standards. *That is the full extent of the remand of the Supreme Court.*" [Emphasis added].[5] Simply put, submits the County, the "task before this Commission to determine are 'whether, and by what amount, the statutory standards of care...forced San Diego to incur costs in excess of the funds provided by the state, and to determine the statutory remedies to which San Diego is entitled.'" The County thereupon concludes, "Unable to deny the validity and merits of the County's claim based on the County's response to the questions asked by the Commission, the Proposed Decision adds a new twist to the proceedings by erroneously concluding that the County was not 'compelled' by the statutory standards of care to incur costs in excess of the funds provided by the State."[6] The County further notes errors in credits determined by the ALJ to its claim for reimbursement.

2. "A reimbursable state mandate is not commensurate with any 'additional costs' that a local government may be required to bear" but is "created only when the state imposes on

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[3] The issues originally presented this tribunal in its initial Proposed Decision were derived from the remand set forth in *County of San Diego v. State of California, et al.* (1997) 15 Cal.4th 68, 111; namely, (1) whether the statutory standards of care compelled the County to incur costs in excess of funds provided by the State, (2) what amount the statutory standards of care compelled the County to incur in excess of funds provided by the State, and (3) what statutory remedies is the County entitled.

[4] The County's Supreme Court reference is to *County of San Diego, supra.*

[5] Section 17000 states: "Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."

[6] The County submits, "This finding is contrary to the Supreme Court's decision in *County of San Diego*, and extends beyond the scope of the Supreme Court's remand to the Commission. The conclusion contained in the Proposed Decision is neither supported by the facts in the record, nor by the findings of fact contained in the Proposed Decision itself. Therefore, the County urges the Commission not to adopt the Proposed Decision."

a local government a new program or an increased level of service under an existing program."[7] The County's obligation to provide health care to medically indigent persons pursuant to section 17000[8] was an unfunded state mandate. Section 17000 effectively denies the County "discretion to refuse to provide medical care to adult medically indigent persons."[9]

3. The State submits that the Commission must always determine whether a mandate is reimbursable[10] and that the Proposed Decision correctly found that the County is not entitled to any reimbursement because the County commingled its California Healthcare for Indigents Program (CHIP) with its County Medical Services (CMS) program, serving the same population with identical services, and because the County limited its legal and economic liability, and, finally, because the County failed to provide salient documentation supporting its claim for reimbursement by the State. The State further submits that some arithmetic errors were effected by the ALJ as credits to the County's claim for reimbursement.

FACTUAL FINDINGS

4. "Before the start of Medi-Cal, 'the indigent in California were provided health care services through a variety of different programs and institutions.'"[11]

A. "County hospitals 'provided a wide range of inpatient and outpatient hospital services to all persons who met county indigency requirements whether or not they were public assistance recipients.'"[12]

B. "'The major responsibility for supporting county hospitals rested upon the counties, financed primarily through property taxes, with minor contributions from other sources."[13]

5. Medi-Cal began operating March 1, 1966, and established "a program of basic and extended health care services for recipients of public assistance and for medically indigent persons [MIP's]."[14] Notwithstanding its initial operation, there remained "a group of citizens not covered by Medi-Cal and yet unable to afford medical care" who remained the

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[7] *City of El Monte v. Commission on State Mandates* (2000) 83 Cal.App.4th 266.

[8] "Section 17000 imposes upon counties a mandatory duty to 'relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident,' when those persons are not relieved and supported by some other means." *Hunt v. Superior Court* (1999) 21 Cal.4th 984, 991.

[9] Defined, for purposes of the decision in *County of San Diego*, "as most individuals who meet financial eligibility requirements for Medi-Cal but are not at least 65 years of age, blind, disabled, or eligible for AFDC. (County of San Diego, supra, 15 Cal.5th at pp. 77 – 80, 100 – 104.) *Hunt, supra* at p. 1004.

[10] *Lucia Mar Unified School Dist. v. Honig* (1988) 44 Cal.3d 830, 836 – 837; *City of El Monte, supra.* Even without the import of these authorities, the Supreme Court's remand to the Commission compelled a determination of the State's reimbursement to the County. *Hunt, supra* at p. 1003, fn. 10.

[11] *County of San Diego, supra* at p. 76.

[12] *County of San Diego, supra.*

[13] *County of San Diego, supra.*

[14] *County of San Diego, supra;* see also *Hunt, supra* at p. 994.

responsibility of California counties.[15] Through 1982, the State provided full funding for MIP medical care.[16]

6. In 1982, the Legislature passed two Medi-Cal reform bills that, effective January 1, 1983, excluded from Medi-Cal most adults who had been eligible under the MIP category.[17] "As part of excluding this population from Medi-Cal, the Legislature created the Medically Indigent Services Account (MISA) as a mechanism for 'transfer[ing] [state] funds to the counties for the provision of health care services.' Through MISA, the state annually allocated funds to counties based on 'the average amount expended' during the previous three fiscal years on Medi-Cal services for county residents who had been eligible as MIP's."[18] By its exclusion of medically indigent adults (MIAs) from Medi-Cal,[19] the State of California effectively transferred responsibility for the medical needs of this population to the counties.[20]

7. "After passage of the 1982 legislation, San Diego established a county medical services (CMS) program to provide medical care to adult MIP's." Between 1983 and June 1989 the State fully funded the County's CMS program through MISA[21] at the following levels:

Fiscal Year	MISA Funds
1/1/83-6/30/83	$19,000,000
83 – 84	36,355,744
84 – 85	37,446,419
85 – 86	43,065,009
86 – 87	41,008,163
87 – 88	41,008,163
88 – 89	41,008,163

[15] *County of San Diego, supra* at p. 77; *Hunt, supra.*

[16] *County of San Diego, supra* at p. 79.

[17] "In 1982, the Legislature excluded from Medi-Cal most individuals who do not fall within the following categories: those at least 65 years of age; blind or disabled persons; and individuals eligible for AFDC." *Hunt, supra.*

[18] *County of San Diego, supra* at p. 79 – 80; *Hunt, supra.*

[19] MIAs are among a class of MIPs who are non-categorically linked. Simply put, these individuals "met the income and resource requirements for aid under [AFDC] but [did] not otherwise qualify as a public assistance recipient.'" Administrative Record, p. 0007; *County of San Diego, supra* at p. 79.

[20] Counties "must provide medical care to medically indigent adults pursuant to section 17000, independent of the statutory scheme that transferred responsibility for such individuals from the state to the counties in 1982." *Hunt, supra* at p. 1004.

[21] *County of San Diego, supra* at p. 80.

With the receipt of such funds from the State of California, the County did not expend any of its funds to provide medical services to MIAs through its CMS Program. The County contracted with four regional contractors, who in turn contracted with health care providers, to provide services to MIAs.

8. Despite rising costs and claims for services, the County, in subsequent years, received MISA funds as follows:

Fiscal Year	MISA Funds
89 – 90	33,947,014
90 – 91	19,842,347

The County claims that by fiscal year 1989 – 1990 and for fiscal year 1990 – 1991, the State was only partially funding the County's CMS program. Faced with reduced State revenues, the County, in fiscal year 1988 – 1989, commenced the development of a new comprehensive health care system for MIAs that would maximize the quality and accessibility to services by MIAs while simultaneously providing a base level of compensation to participating health care providers.

9. By December 24, 1990, the County claims "it exhausted state-provided MISA funds" and, faced with a shortfall,[22] the County's "board of supervisors voted in February 1991 to terminate the CMS program unless the State agreed by March 8, 1991, to provide full funding for the 1990 – 1991 fiscal year." The State refused to provide additional funding whereupon the County "notified affected individuals and medical service providers that it would terminate the CMS program at midnight on March 19, 1991."[23] The County, relying on the Declaration of Sandra McChesney, former Chief of the County Medical Services, claims it "was not until the County committed millions in County general funds to the CMS program, that had previously been earmarked for discretionary county services, that the crisis was averted and the CMS system continued to function."[24]

10. For fiscal year 1990 – 1991, the County received funds as follows:

A. $19,842,347 in Medically Indigent Services Program (MISP) funds from the State with a credit to the State in the sum of $294,003 for interest earned by the County on the funds.[25]

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[22] See also *Hunt, supra*.

[23] *County of San Diego, supra* at p. 80.

[24] County of San Diego's Comments to Proposed Decision, p. 73. A review to the referenced paragraph of Ms. McChesney's Declaration does not, however, provide the same particularity to "millions" or "earmarked" services averred in the County's instant hyperbole to the Commission.

[25] The stipulation entered into by and between counsel as set forth in the transcript "is that the County credited the State with $24,003 in interest earned by the County on the MISP funds for 90/91." The transcript, as correctly reflected by the County in its written submission, is for $294,003.

B. $3,462,889 in hold harmless money from the State.[26]

C. $3,598,261 in federal grant money known as Legalized Indigent Medical Assistance through the State of California to mitigate the effects of the Immigration Reform and Control Act of 1986 via the State Legalization Impact Assistance Grant (SLIAG) Program. Of such amount, the County spent $2,199,951 on its CMS program.[27]

D. $18,942,077 in California Healthcare for Indigents Program (CHIP) funds from the State.

The County considers its CMS Program its MISP Program. County avers that the total amount received by the County from or through the State to be credited for medical services to MIAs is: $25,799,190;[28] the State counters that the County received, with the inclusion of CHIP funds, $43,571,267. The County responds that CHIP funds should not be properly considered by this tribunal for inclusion.[29] Seeking reimbursement for its CMS Program, the County, on December 18, 1991, submitted an invoice to the State Controller for its fiscal year 1990 – 1991 uncompensated expenditures.[30]

11. The County claims it spent $41,072,858 in its CMS program to provide appropriate medical care to its indigent population of 22,582 unduplicated users in 1990 – 1991.[31] The County argues that "[f]or fiscal years 1986 – 87 through 1988 – 89, the State provided the County funding at the level of $41,008,613 through its MISA account. However, for fiscal year 1990 – 1991, that funding was reduced to $19,842,347. During that latter fiscal year, the County maintained the CMS program at the $41 million level, and the County has now established that the medical services which it provided to adult MIP's were consistent with and did not exceed Medi-Cal standards. That level of care was also consistent with Welfare & Institutions Code sections 10000 and 17000 and the case law interpreting those statutes." Mindful of contributions effected by the State for fiscal year

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[26] See Welfare & Institutions Code §16991.

[27] The County's reference to William Burfitt in its post-hearing submission is inapposite and not dispositive. For purposes of this proceeding on remand, the Attorney General's objection is overruled.

[28] This amount is derived, on remand and reconsideration by the ALJ, from the County's "Comments to Proposed Decision", p. 68. This amount modifies the previous finding of $25,529,190 in the Proposed Decision. The $25,799,190 is derived from the sum of $19,842,347; $3,462,889; $2,199,951; and $249,003.

[29] CHIP funds supplement not supplant extant programs. Revenue and Taxation Code Section 30125.

[30] *County of San Diego, supra* at p. 83. Although the County originally claimed unfunded mandates for both fiscal years 1989 – 1990 and 1990 – 1991, its claim to the Commission on State Mandates is only for 1990 – 1991 in the amount of $15,164,350.

[31] While the County, incident to its submission to the Commission following issuance of the Proposed Decision, submits this claim is "uncontradicted"; it is correct in observing that the ALJ did not make a specific finding on its claim inasmuch as the County's ability to categorically support such claim lacks, as posited by the State, competent and credible source documentation. That having been said, the County has, nevertheless, satisfied the Commission's July 1, 1997 request to "identify or report the number of adult MIP's served during fiscal" year 1990 – 1991 and to "calculate the amount of money spent on medical services...on behalf of adult MIP's" during that fiscal year. The County, however, fails to distinguish its response from its obligation to present competent and credible evidence.

1990 – 1991, the County submits there remains a shortfall of slightly more than $15.1 million owed by the State.

12. During fiscal year 1990 – 1991, the County claims it incurred and paid CMS Program expenses, as follows:

A.	Direct Program Costs[32]	$36,254,278	
(1)	Professional Services:	$32,229,861	
a.	Hospital Pool:	$17,149,487[33]	
b.	Specialty Pool:	$10,704,421[34]	
c.	Clinic Pool:	$ 4,225,660	
d.	Eligibility Physicals:[35]	$ 140,580	
(2)	Administration Services:	$ 4,034,130	
B.	Indirect Program Costs[36]	$ 1,632,554	
(1)	Department Overhead:	$ 1,176,257	
(2)	External Overhead:	$ 456,297	
C.	Other Costs[37]	$ 2,944,352	
(1)	Social Services:	$ 130,132	
(2)	Drug & Alcohol Services:	$ 135,000	
(3)	Primary Care Services:	$ 20,894	

[32] This denotes amounts paid for professional services, salaries and benefits paid to County employees, services and supplies expended by the County on the CMS Program, debt service, fixed asset costs and Medicus administration.

[33] This amount excludes $4,671,237 in CHIP funds.

[34] This amount excludes $2,694,600 in CHIP funds.

[35] To continue receiving general relief payments, CMS patients were required to be in a work program; however, if such patients were disabled and unable to participate in a work program, benefits would be denied unless examined and certified as unfit to work. The County, through the Primary Care Division of the Department of Human Services, contracted with community clinics to provide physicals determining CMS Program eligibility.

[36] Indirect Program Costs include a portion of the Department of Health Services overhead as well as a lesser portion of the County's overall overhead costs.

[37] Other Costs include CMS funds allocated and expended by the County's Department of Social Services, Department of Health Services, Department of Alcohol and Drug Abuse Services, Primary Care Services, and Department of Mental Health Services.

(4) Mental Health Services: $ 2,658,326[38]

13. Faced with forthcoming fiscal shortfalls, the County, commencing with the 1989 – 1990 fiscal year, developed and undertook a reimbursement pool structure for its CMS program that transferred the risk of financial loss (attributable to service costs and funding) from the County to its contract providers. The County established reimbursement pools from which it paid providers. Pool allocations were set and capped by the County at the beginning of each fiscal year based on final State Budget approval once county allocations were known. Through these provider contracts, the County limited its liability for payments to the amounts in its capped reimbursement pools, thereby shifting risk of financial loss to its CMS program contract providers. To reimburse providers, the County established three main reimbursement pools:

A. The Hospital Pool.

(1) The Hospital Pool is further subdivided into two pools: the Hospital Discretionary and the Hospital Formula.

(2) Providers are reimbursed on the basis of a point system established by the County and set forth in its provider contracts. The point system awards participating hospitals a certain number of points for various services provided to CMS patients. Non-participating hospitals (i.e., non-contracting hospitals) are paid at a single and much lower point rate, regardless of the service provided nor is every CMS patient service paid at the same rate. In contrast, a participating (i.e., contracting) hospital is paid at a higher rate for the same service.[39]

(3) Providers are paid throughout the year based on a formula which considers the overall amount in the reimbursement pool in relation to the number of points accumulated by the provider in approved claims.

a. Effectively, the County's unit-of-service costs are not fixed but vary, depending on the amount of money in the pool and the number of approved services provided. The more services provided, the lower the unit-of-service

[38] Despite the County's claim of having incurred expenses in the sum of $2,900,000, competent and credible evidence established that it actually expended $2,658,326 of CMS funding through its mental health program.

[39] For example, in its hospital contract, the County assigns various hospital services certain point values. Payments to providers are based on a formula that considers the overall amount in the reimbursement pool in relation to the number of points accumulated by the provider in approved claims. Accordingly, the County's unit-of-service costs (i.e., point costs) are not fixed but vary depending on the amount of money in the pool and the number of approved services provided. If more services are provided and approved, overall CMS program costs do not increase; rather, using the formula, the dollar-value-per-point simply decreases so that overall costs do not exceed the amount in the reimbursement pool.

cost, thereby limiting final costs within the limits of the amount in the reimbursement pool.

b. The final payment rate per point was not determined by the County until the end of the fiscal year, and was based on the amount of funds expended from the "reimbursement pool" and the total number of points accumulated throughout the year.

(4) In its hospital contracts, the County limited its liability for payment to the funds in the reimbursement pool, regardless of the number of patients served or the level of services provided.

B. The Physician Pool.

(1) The Physician Pool is further subdivided into two pools: the Physician Specialty and the Physician Emergency Services.

(2) Providers, pursuant to provider contracts, are reimbursed during the year at interim rates of 100% of Medi-Cal rates. The County provides in its contracts that the total pool amount is available for payments to providers, but limits its liability to this amount.

(3) To avoid depleting its pool amount, its provider contracts permit the County to adjust the interim payment rate, after a review of the pool within the first nine months of the contract year. Based on its review, the County, in order to avoid depleting its pool, reserved the right to adjust the rate for payments already made and for future payments.

(4) The contract further permits contracting physicians to participate in the County's "risk pool." This provision provides that any funds remaining in the pool after all authorized claims have been paid will be paid to contracting physicians based on a percentage of payments made throughout the year. Such payments (not to exceed 135% of Medi-Cal rates) are not for additional services or additional patients treated.

C. The Clinic Pool.

Contract providers are reimbursed during the year at an interim dollar rate per visit for a pre-approved and specified monthly number of CMS Primary Care visits for each Clinic. The Clinic contract particularly provided "in the event that a Clinic site provides more CMS Primary Care Visits than approved..., the excess visits will be at full risk." Payment for these visits will be made on a pro-rated basis, only if funds

remain in the Pool after all visits are paid at the maximum rate." A contract provision further provides that funds remaining in the Primary Care reimbursement pool at the end of the contract year, after all approved pool claims have been paid, will be distributed to Clinics on a prorated basis. Such payments are not for additional services or additional patients treated.

The County asserts that neither the Hospital Formula sub-pool[40] nor the Physician Emergency Services sub-pool[41] represent CMS program pools, since they contain CHIP funds, and since the State directs how such funds (CHIP) are to be expended on indigent health care. On the other hand, the County submits that the three remaining pools: the Hospital Discretionary, Physician Specialty, and Clinic are CMS program pools (although CHIP funds are commingled in two of these three pools).[42] Risk of loss for excess service costs were shifted to the contractors by either express provisions stating excess services will be provided at the contractors' full risk or by utilizing a payment formula to control unit-of-service costs to match initial pool funding levels. As an incentive to contract, the County promised contracting providers payment of all funds allocated to the pool; therefore, if after all claims are paid at the maximum dollar amount and money remains in the pool at the end of the fiscal year, contract provisions specify that any remaining funds will be distributed to contract providers based on the number of points accumulated for services provided throughout the year. Non-contracting hospitals, as a further incentive to contract with the County, are paid at a single and much lower rate for all services (e.g., contracting hospitals' points ranged from 1 – 15 points, depending on the type of service rendered; however, non-contracting hospitals were paid 2.75 points for all services, regardless of type).

14. In fiscal year 1990 – 1991, the County contracted with Medicus (later "Managed Care Solutions, Inc." and now "Lifemark Corp.") to administer its CMS program. As part of Medicus' administrative responsibilities, it facilitated the County's negotiation of contracts with healthcare providers and made payments to CMS' program providers. The County acknowledges that for fiscal year 1990 - 1991:

A. The "*estimated* level of funding for the hospital pool was $17,000,000 and expressly gave the hospitals the right to terminate the contracts on ten days notice if 'State funding [was] significantly reduced or not received.' In addition, the hospitals could terminate on sixty days notice for any reason."[43]

B. "The contracts with the individual and group Specialty Physicians providers stated that the *estimated* level of funding for the Specialty Physician Pool for fiscal year 1990 – 1991 was $10,000,000. These contracts also allowed the providers to terminate the contracts in the

[40] This subpool included $6,055,385 in CHIP funds.

[41] This subpool included $3,281,011 in CHIP funds.

[42] No CHIP funds were used to pay for Clinic services.

[43] County of San Diego's Comments to Proposed Decision, p. 72.

event the State failed to fund its mandated CMS obligation at historic and expected levels."[44]

C. "[T]he agreements with the Primary Care Clinics provided that the *estimated* level of funding was $4.2 million and allowed the clinics to terminate the contracts if state funding was substantially reduced."[45]

15. As the County operated its CMS Program, there is no extant evidence that suggests the County provided a higher level of service (i.e., standard of care) pursuant to any state mandate. The County's 1990 – 1991 CMS Program is not driven by the number of patients served or level of service provided but, rather, by the amount the County was prepared to pay for services during the extant fiscal year as a consequence of funds available for disbursement.

A. Without modifying eligibility requirements or the scope of services provided patients, the County controlled CMS Program funding, contracting, and payment processes that cap reimbursement.

B. The County CMS Program controlled unit-of-service reimbursement within particular limits of fiscal liability.

C. The County, rather efficiently and responsibly, allocated funds to its capped "reimbursement pools" and, thereby, shifted the risk for financial loss from excess service costs to its contract providers.

The County did not experience uncontrolled costs or an excessive amount of services by its employment of its service delivery model. Employing such a model, both the reimbursement pool structure and provider contract provisions limiting the County's liability for payment to the amounts in its reimbursement pools, final CMS Program costs are determined sufficiently early in the fiscal year, when State funding is known and reimbursement pool allocations are made. The County's CMS Program costs are therefore contained, regardless of the number of patients served, or the number or level of services provided. In the event of potential pool shortages, County and Medicus staff acknowledged to state auditors that funds would be shifted between the pools during the close-out process.

16. Seeking to audit the County's claim for CMS Program reimbursement, state auditors from the Office of State Audits and Evaluations, Department of Finance, requested documentation supporting the County's claim and, following efforts to elicit documentation, Department of Finance auditors claim:

A. There exists no competent credible evidence to support the County's claim of $41,110,814 in MISP costs for fiscal year 1990 – 1991.

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[44] See footnote 43.

[45] See footnote 43.

(1) The County failed to provide either its original claim, a copy of its original claim, or backup records, original or copies.

(2) County records supporting its claim were destroyed.

a. Evidence presented this tribunal competently and credibly established that the County, although having maintained its records pending litigation, subsequently destroyed various records during the subsequent pending of this referenced audit thereby impairing competent audit completion.

b. Although some documents containing requested information were presented to the state auditors on their first visit to the County on March 15, 1999; thereafter, County staff, having been advised that the audit review was adversarial by County Counsel, were instructed not to provide documents unless specifically identified by the auditors.

(3) Lacking appropriate documentation, an audit of the County's claim could not be competently performed.

a. Requests for documentation by state auditors were ignored.

b. Inconsistent versions of documents were submitted to state auditors.

c. At the hearing, the County produced voluminous records, including cancelled checks, purporting to support its claim of CMS Program expenditures in the sum of $41M. The evident animosity between the County and State functioned to clearly impede the audit, impair candor, and limit communication. The effect circumscribed this tribunal's ability to fully and competently determine the scope of the County's CMS Program. Each party now concedes the value of an audit, however the County suggests an independent audit to which the Attorney General objects. While the Attorney General invites this tribunal's recommendation to the Commission on State Mandates for an audit—the invitation is declined. The CMS Program expenditures as relevant to the administered reimbursement pools are not dispositive to the County's 1990 – 1991 claim.

B. Generally accepted accounting principles require, inter alia, a system to identify and match revenues (credits) and expenditures (debits) to identify a population of related transactions for an account. Following receipt of funds from the State and disbursal by the County to Medicus, the County failed to account separately for the expenditures (debits) relating to CHIP revenues (credits) or the MISP revenues (credits) in its CMS Program expenditures.

(1) Medicus did not maintain separate accounting of CHIP and MISP funds it received through the drawdown transfers from the County.

(2) Once CHIP and MISP funds were deposited into Medicus' bank account and allocated into the pools, the funds became indistinguishable between CHIP and MISP. Neither the County nor Medicus, following commingling, can properly, competently or credibly account for the funds' final allocation.

(3) All CMS Program expenditures for provider payments were made by Medicus as homogeneous pool expenditures.

(4) The County, lacking the ability to identify pool expenditures that relate to CHIP revenues or MISP revenues, cannot separately account for the funds or support its claim for reimbursement.

(5) CHIP contracts did not identify which services or pool expenditures would be CHIP expenditures or which patients were to be served by the contracts. CHIP contracts were not accounted separately from MISP contracts.

(6) The County submitted Medicus invoices as support for its claimed $32,102,518 MISP costs for its CMS Program. Such invoices are based on "draw requests" which merely represent amounts to be deposited into Medicus' bank account to pay anticipated future claims. The Medicus invoices presented by the County in support of its claim represent CMS Program revenue—not CMS Program expenditures. When asked by auditors for the CMS Program expenditures relating specifically to the $32,102,518 MISP funding, County staff acknowledged that with the CHIP and MISP commingling, related expenses could not be identified.

a. The County, although claiming the two programs are separate, is unable to competently and credibly identify which specific expenditures are properly CHIP and which specific expenditures are properly MISP.

b. The County, having commingled funds in its reimbursement pools and outsourced administration, is unable to competently and credibly identify the individual patients or services related only to MISP funds.

c. The CMS Program, as administered and funded by the County, included both CHIP and MISP funding to match CMS Program revenues with concomitant expenditures; consequently, the County's commingling of State CHIP and MISP funds for healthcare services provided to its MIA population necessitates the inclusion of disbursed CHIP monies in determining the amount of funds provided by the State for MIA healthcare.

17. Factors concerning the credibility of evidence are contained, in part, in Evidence Code Sections 412, 780, 786, 790 and 791. When applied to the evidence herein, this tribunal concludes, on balance, and by a preponderance of evidence, that:

A. The County CMS Program expenses exceeded its MISP allocation from the State in fiscal year 1990 – 1991; however, CMS Program services and economic risk, shifted to the private sector, were administered and rendered within the appropriate statutory standards of care.

B. The County, in fiscal year 1990 – 1991, had:

(1) An undisbursed CHIP credit in the sum of $185,000.

(2) A 1989 – 1990 fiscal year Short-Doyle Program non-categorical surplus in the sum of $900,000,

(3) SLIAG funds allocated to and for mental health services in the sum of $41,244.

(4) A Medicus credit in the sum of $424,096.

(5) SLIAG funds diverted to other than its CMS Program in the sum of $1,398,310.

(6) Unaccounted (but disbursed) CHIP funds in the sum of $657,654.

(7) The County expended $2,658,326 of MISP funds to its County Mental Health Department.

C. The Attorney General posits that the County's surplus funds in the 1989 – 1990 and 1990 – 1991 militates consideration by this tribunal; however, this tribunal cannot readily overlook the obligation imposed on the State of California to eligible medically indigent. That having been said, it becomes equally apparent that a county cannot administer a program beyond the mandate of the State and, thereafter, competently claim reimbursement. Discerning County CMS Program expenses in the sum of $40,831,184, it is evident that any claims against the State of California by the County[46] must be reduced as follows:

(1) Since after 1982, MIPs have been eligible for the Short-Doyle mental health program; further, the Short-Doyle Act placed limits on the County's obligation for funding mental health services,[47] no statutory mandate existed that compelled the levels of service or fiscal constraints compelling the diversion of the County's claim for $2,658,326 to its Mental Health Department's Short-Doyle Program from the CMS Program.

(2) SLIAG funds in the sum of $41,244 to and for mental health services, as distinct from Short-Doyle Program services, do not compel reduction of the County's claim.[48]

(3) Medicus and the County acknowledge a credit incurred in the sum of $424,096. Such sum accordingly mitigates the County's claim.[49]

(4) The County claims it incurred CMS Program expenses of $40,831,184 payable through Medicus in the sum of $36,254,278; however, competent and credible evidence established that Medicus only invoiced $32,102,518, but expended $32,220,148; despite a claim for $32,229,861 in professional services. Despite its claim, the County did not competently account for the $9,713 in additional claimed expenses. Accordingly, this tribunal must further reduce the County's claim by such sum.

(5) The State submits that the County's fiscal year Short-Doyle Program surplus compels mitigation of the County's claim. While this tribunal is reluctant to determine that a county must

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[46] Subtracting $25,799,190 from $40,831,184; it is determined that the County's claim is $15,039,994.

[47] *Gardner v. County of Los Angeles* (1995) 34 Cal.App.4th 200, 222; *Board of Supervisors v. Superior Court (Comer)* (1989) 207 Cal.App.3d 552, 558; Welfare and Institutions Code Section 5709.

[48] Welfare and Institutions Code Section 14021(a) provides, in pertinent part, that "health care shall include mental health services provided by a county."

[49] As correctly noted by the Attorney General in his post-hearing submission, the reference is derived from the Medicus Fiscal Statement for the CMS fiscal year ending July 1991.

exhaust its fiscal surplus when seeking reimbursement relating to a state mandate, the source of the surplus, for which a credit is allowable, arises from a revenue offset derived by the County's diversion of CMS funds to Short-Doyle Program services—a program not mandated for CMS fund inclusion.

(6) The State paid the County SLIAG funds in the sum of $3,598,261 of which $1,398,310 was diverted to other than the County's CMS Program. The State is entitled to a further credit in the sum of $1,398,310.

The net effect of the allowable credits and disallowable expenses thusfar imposed reduce the County's established CMS Program expenses by $6,274,343.

D. The County objects to the State audit report as untimely and moved to strike the report in toto.[50] This poses a particularly troubling matter. Simply put, the County would have this tribunal compel the State of California to tender public funds on a record that, in part, lacks competent and credible source documentation and exemplifies the worse in County and State cooperation. Having made its claim for reimbursement, this tribunal concurs that an obligation was placed on the State of California Controller to competently and timely conduct an audit review of the County's claim. The State did not do so. On the other hand, the County's effort to benefit from its summary disposal of documents and subsequently intransigent cooperation begs particular scrutiny and does not preclude an audit review by the Department of Finance.[51]

(1) It is clear that the commingling of MISP and CHIP funds in the implementation of its CMS Program prevents this tribunal from categorically relegating funds to population services. While the record presented this tribunal identifies most CHIP funds,[52] $657,654 in CHIP funds remains unaccounted. Even without consideration of the audit report's import, the receipt by the

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[50] The County cites Government Code Section 17558.5 which provides, in pertinent part: "A reimbursement claim for actual costs filed by a local agency ... is subject to audit by the Controller no later than four years after the end of the calendar year in which the reimbursement claim is filed or last amended." This provision, however, did not go into effect until January 1, 1994—over two years after the County's claim for reimbursement, which was not otherwise limited by an audit completion period by the State Controller or, more importantly, the Director of the Department of Finance, was filed. The County's objection to the audit report is overruled and motion to strike summarily denied. Indeed, as the Supreme Court articulated in *Hunt, supra* at p. 1003, fn. 10, the judgment in *County of San Diego* concerns "the state's reimbursement for the county's previous expenditures. ..."

[51] Government Code Section 13070; *State Bd. of Ed. V. Levit* (1959) 52 Cal.2d 441; *Treu v. Kirkwood* (1954) 42 Cal.2d 602; *State v. Brotherhood of R.R. Trainmen* (1951) 37 Cal.2d 412; *Ireland v. Riley* (1936) 11 Cal.App.2d 70.

[52] In the prior Proposed Decision, the ALJ incorrectly included $1,582,190 in SB12/612 (PES) expenditures.

County of funds it cannot now or timely attribute to any particular account compels reduction of its claim.[53]

(2) It is further established that the receipt of $18,942,077 in CHIP funds did not necessitate the County's expenditures at the $41M level on its CMS Program in 1990 – 1991 but a Maintenance of Effort ("MOE") as set by their net county costs in fiscal year 1988 – 1989. It is equally evident that to meet its MOE, the County was required to spend a certain amount of its funds on public health and inpatient/outpatient (indigent) programs as a whole. Once spent, it was considered to have met its county match. Any amount spent above this "county match" became the "county overmatch" which, thereby, became the county's net county cost or its MOE requirement. The County, from the evidence presented this tribunal, failed to properly administer its receipt of CHIP funds in accordance with its Standard Agreement with the State of California. MOE is not determined on an individual program basis but on an overall basis for healthcare programs as a whole, including the County's public health and CMS Programs. There is no statutory requirement that spending occur on an individual program at a certain level.

The County overstates, in this proceeding, the import of the audit. What becomes of particular significance is the inconclusive result of this audit that is no less evident to this tribunal from the state of the record provided. While the County's motion to strike has been denied; the inconclusive nature of the audit is not dispositive to this tribunal's determination. The County's administration of its CMS Program, including its pool reimbursement methodology, functioned to leave unresolved the ultimate allocation of public funds with due regard to accounting and audit principles. Irrespective, however, of the pool reimbursement methodology, the cavalier public financial administration demonstrated by the County subsequently exacerbated by staff intransigence[54] cannot be readily cured by this tribunal and did little to support the County's obligation or establish its claim for reimbursement.[55]

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[53] With the combination of credits and disallowable expenses, this effectively reduces the County's claim for reimbursement to $8,765,651. The County's belated effort to account for its remaining CHIP balance is deemed untimely.

[54] The County, in its submission compelling reconsideration by this tribunal, observes that the State demonstrated a "'cavalier' attitude regarding its responsibility to pay for medically necessary care for MIA's that precipitated the crisis." It becomes clear to this tribunal that particular culpability may be ascribed to the parties as a consequence of political decisions. That having been said, this tribunal need only concern itself with the issues at hand that arise from the instant claim for reimbursement by the County.

[55] The County, despite its comments to the Commission and in reconsideration by this tribunal, overlooks the gravamen of this proceeding. The County appears to posit that its claim for reimbursement must be honored by the Commission regardless of the ability of such claim to withstand the scrutiny of a public audit. The original mandate imposed by the Commission on this tribunal was to determine, pursuant to the Supreme Court's direction, (1) whether the statutory standards of care compelled the County to incur costs in excess of funds provided by the State, (2) what amount the statutory standards of care compelled the County to incur in excess of funds provided by the State, and (3) what statutory remedies is the County entitled. *County of San Diego, supra* at p. 111.

E. It becomes apparent that a level of services was to be rendered the medically indigent. Aware of forthcoming financial shortfalls, County administration competently and responsibly developed its reimbursement pool method that effectively transferred its economic risk.[56] It is readily acknowledged that certain fiscal levels were anticipated; however, regardless of what funds were, in fact, received from either the State of California or the federal government through the State, risk—economic risk—was to be solely borne by contract providers—not the County. The State, accordingly, submits that the transfer of such risk from the County to contract providers obviates any County claim for reimbursement. What emerges from the record presented this tribunal is that the County's claim that it was compelled to incur costs in excess of funds provided by the State to meet statutory standards of care is not established. Clearly, reimbursement, if any, would not inure to the public treasury but, instead, to private service providers who contracted with the County cognizant of economic risk.

F. Of further import to this tribunal is the significance of the County's commingling of funds as it relates to population services. There is no doubt that services were, in fact, competently rendered the medically indigent during the fiscal year 1990 – 1991 administration of the CMS Program by the County. What is consequently not established as a result of the lack of competent source documents and inappropriate commingling is that the County did not incur CMS Program expenses, nor any specific amount, in excess of funds provided by the State.

LEGAL CONCLUSIONS

1. In the original Proposed Decision submitted to the Commission, the ALJ determined:

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[56] Commissioner Beltrami, in the Commission proceeding on November 30, 2000, raises a cogent and provocative issue: "Madam Chair, I have just one particular concern, and that is the hearing officer's statements regarding the contracts with the HMO. It seems to me that when a local party has used prudent fiscal management, which I think was probably the concern of the county in this instance, that if we turn around and say, well, these people did a good job, they saved money; and, therefore, if there's no cost...I'm just concerned on that because that whole philosophy can be carried a long way. And I would like to see that at least discussed by the hearing officer again without opening up every other avenue. But that's just my own personal concern." It is abundantly clear that the County embarked upon a program that demonstrated prudent and responsible fiscal management in the administration of its program by transferring economic risk to the private sector, meeting thereby the statutory standards of care without incurring costs in excess of funds provided by the State. While the passage of time, record management, and other factors impair the County's claim for reimbursement, this Decision should not stand for the proposition, as evinced by Commissioner Beltrami, that prudent fiscal management precludes properly submitted and documented claims for reimbursement.

"Cause does not exist to find that the statutory standards of care pursuant to Health and Safety Code §1442.5, and Welfare and Institutions Code §§10000, et seq., 16703, et seq., and 17000, et seq., in conjunction with Government Code §13070, compelled the County to incur costs in excess of funds provided by the State...."[57] and

"Cause does not exist to find that the statutory standards of care pursuant to Health and Safety Code §1442.5, and Welfare and Institutions Code §§10000, et seq., 16703, et seq., 17000, et seq., in conjunction with Government Code §13070, compelled the County to incur any amount in excess of funds provided by the State...."[58]

Following reconsideration of the parties' submissions, it is abundantly clear that the County has missed the import of the ALJ's determination as to Legal Conclusions 1 and 2 in the original Proposed Decision. Compulsion as referenced by the ALJ is not on the program required to be implemented by the County pursuant to section 17000 (as perceived by the County in its post-hearing submission) but on the costs compelled to be incurred by the County in the program's implementation. Indeed, the County's claim of financial compulsion is simply belied by the very nature of its innovative (and financially prudent) program. Accordingly, cause does not exist to find that pursuant to the statutory standards of care set forth in Health and Safety Code §1442.5, and Welfare and Institutions Code §§10000, et seq., 16703, et seq., 17000, et seq., in conjunction with Government Code §13070, the County necessarily incurred costs in excess of funds provided by the State as set forth in Findings 1 – 17.[59]

2. Cause does not exist to find that pursuant to the statutory standards of care set forth in Health and Safety Code §1442.5, and Welfare and Institutions Code §§10000, et seq., 16703, et seq., 17000, et seq., in conjunction with Government Code §13070, the County necessarily incurred any amount in excess of funds provided by the State as set forth in Findings 1 – 17.

3. Cause does not exist to find pursuant to Health and Safety Code §1442.5, and Welfare and Institutions Code §§10000, et seq., and 16703 et seq., and 17000, et seq., in conjunction with Government Code §13070, that the County is entitled to any statutory remedies as set forth in Findings 1 – 17.

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[57] Legal Conclusion 1 of the original Proposed Decision.

[58] Legal Conclusion 2 of the original Proposed Decision.

[59] Having concluded, on reconsideration, that several comments of the parties compel modification of the Proposed Decision as set forth herein; particularly with respect to credit offsets to the State; this tribunal otherwise concludes that the original Proposed Decision does not erroneously conclude that the County is not entitled to any recovery.

ORDER

The claim of the County of San Diego is dismissed.

Dated: 12-29-00

JAIME RENÉ ROMÁN
Administrative Law Judge
Office of Administrative Hearings